# Clinical Section

## Open Versus Closed Reductions of Fractures*

*By*

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I suppose there will always be differences of opinion as to whether certain fractures should be treated by open or by closed methods, but there should be no differences of opinion regarding certain fundamental principles which should be strictly observed by every surgeon who accepts the responsibility of converting a closed into an open fracture. Some of these principles are:

1. If the surgeon is in doubt as to whether to employ open or closed reduction he should first try closed methods, holding open reduction in reserve.
2. No surgeon should accept the responsibility of converting a closed into an open fracture unless he has had sufficient surgical training and experience to have acquired a fixed automatic habit of doing his surgical work with scrupulous attention to the most exacting aseptic details.
3. An indispensible requirement is that the surgeon can conduct his operation in a surgical environment of such character that every link in the chain of asepsis shall be as perfect as human foresight, ingenuity and conscience can make it. This does not necessarily mean that such operations should be undertaken only in large hospitals. There are some large hospitals where the technique is lacking in certain important details; and on the other hand, there are some small hospitals where aseptic technique has been developed to a standard that leaves little to be desired. It is equally true, however, that in some small, poorly equipped hospitals a surgeon cannot undertake serious bone operations without serious risk of calamity to the patient and impairment of his own reputation.

There is nothing new or original about these principles but the necessity of constantly emphasizing them has often been strongly impressed upon me through having had to perform amputations of limbs which could easily have been saved and made functionally useful had more conservative methods of treatment been adopted. It is as true in connection with surgery as in many other departments of life that sometimes "Fools rush in where angels fear to tread."

I have often wondered whether the work of Arbuthnot Lane in popularizing the plating of fractures has done more harm than good. It is possible for a method of treatment to become more or less of an obsession with its originator. I once enjoyed the opportunity of seeing Mr. Lane operate in one of the hospitals in London. The patient had a simple fracture of the tibia, and not one, but two long heavy metal plates were applied. The technique of the operator was beautiful and his mechanical skill and deftness could not but excite admiration, but the fly in the ointment was that this simple fracture could have been treated successfully by any practitioner who was competent to treat fractures at all, by simply applying a plaster of Paris cylinder and carefully molding the limb to proper shape while the plaster was hardening. While Mr. Lane was operating, one of his internes came into the room, looked on interestedly for a few moments and then remarked to those of us who were standing around, "I struggled for an hour and a half yesterday plating a T fracture of the humerus." I had just come from spending some time in the clinic of Sir Robert Jones of Liverpool, and I knew perfectly well that Sir Robert would have reduced that T fracture of the elbow by a simple manipulation which would not have occupied more than a couple of minutes, and would almost certainly have secured a better functional result, without the risk of an open operation occupying an hour and a half.

Few fractures will ever require treatment by open reduction except those of the shafts of the long bones. The great majority of these can be successfully managed by closed methods but there are some in which the best results can be secured only by open operation. There is one test which for many years I have regarded as reliable in deciding the necessity for open operation. If on gentle manipulation no crepitus can be elicited, I decide to operate. If the ends of the fragments are in contact, crepitus will be present, but if crepitus is absent it means that muscles, periosteum or other soft tissues are interposed between the fragments and will almost certainly provide a mechanical obstacle to bony union. In operating for non-union I have so often encountered interposition of soft tissues, that I have come to regard it as the one great cause of non-union in fractures.

### Types of Fracture Suitable for Open Reduction

The time allotted to this paper permits the discussion of only a very few individual fractures. In my own practice I am more inclined to employ open reduction chiefly in fractures of both bones of the leg, in some spiral fractures of the femur with overlapping, in certain fractures of both bones of the forearm and in fractures of the patella and olecranon process than in other cases. If the tibia alone is fractured it can usually be treated conservatively; but if the fracture of the tibia is oblique and the fibula is also broken the application of a plate is relatively simple and secures such perfect apposition, and with a minimum of

* Notes from a lecture delivered during the Post-Graduate Course on Traumatic Surgery, Medical College, University of Manitoba, February, 1938.

succeeding discomfort to the patient that I am inclined to employ this method. The bad results one constantly sees from fractures of both bones of the leg treated conservatively makes the open method of treatment very tempting. Where the tibia is badly comminuted it may be impossible to employ a plate and here we have available a method which is a compromise between open and closed methods. A pin is passed transversely through the tibia in the neighborhood of the tibial tubercle, and another pin either through the lower fragment or through the os calcis or just above the os calsis, and while an assistant makes traction and holds the limb in good alignment, a plaster of Paris dressing is applied incorporating the pins in the plaster. This method, if carefully carried out, will effectually maintain the corrected relation of the fragments. Conservative methods will give good functional results in most fractures of the femur but the shortening and deformity which one encounters so frequently is sufficient evidence that such methods as are sometimes employed leave much to be desired. The old method of applying extension by a weight attached to a cord passing over a pulley at the foot of the bed and fastened to adhesive straps on the patient's extremity, is an unsatisfactory and perfunctory method of treatment. What has come to be known as "Balanced Traction" undoubtedly gives good results in the hands of those who have gained experience with it and who are willing to give detailed attention to the management of the case after the traction has been applied. Some of the methods which are recommended and used involve the use not only of a Thomas splint but of such a number of different weights and pulleys attached to a Balkan frame as to give the patient and his bed an appearance suggesting a full rigged ship. Such complicated apparatus must certainly appear unnecessary to those who have learned simpler methods.

With very young children it is doubtful if there is anything superior to the method of vertical traction applied to both lower extremities.

## Splint for Children

For older children the principle embodied in the Thomas splint is incomparably the best method of conservative treatment. As the late Sir Robert Jones pointed out, the apparatus employed to produce traction should for practical purposes become a part of the patient. This is where the old method of traction by means of a weight and pulley fails lamentably, because the friction of the patient's limb against the bed, and the necessary movement of the body involved in using the bed pan or in making changes of position to secure greater comfort, causes the degree of traction to vary and permits muscle spasm; whereas, a Thomas splint properly applied produces traction which is unvarying and continuous. For many years, however, Dr. MacKinnon and I have been using an apparatus which is even more efficient than the Thomas splint and which is represented in figures 1 and 2. This method preserves the advantages of the Thomas splint while at the same time eliminating its most objectionable feature, namely, the uncomfortable pressure about the upper part of the thigh caused by the ring of the splint and sometimes resulting in pressure sores. We speak of this method as the Hoke traction because it was originally introduced by Dr. Michael Hoke of Atlanta, Georgia, for the treatment of certain deformities resulting from infantile paralysis. In the original Hoke method the short arm of the splint was incorporated in a plaster collar applied to the upper part of the fractured thigh but Dr. MacKinnon introduced the modification which makes any plaster on the fractured side unnecessary. As will be seen in the illustration this splint is incorporated in a plaster spica applied from the nipples to the toes on the well side, the sole of the foot being abundantly padded. When the wing nut below the splint is tightened it of course tends to push the plaster up on the patient's body, but this cannot take place to any extent on account of the foot on the well side being incorporated in the plaster. The result is that counter pressure instead of coming upon the ring of the Thomas splint

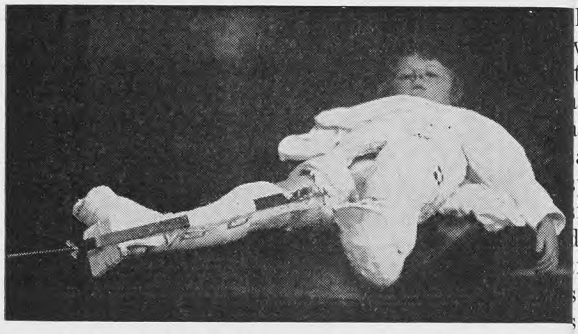

Fig. 1—Dr. Michael Hoke's Method of Fraction.

Fig. 2—Dr. A. P. MacKinnon's Modification of Hoke Fraction.

applied to the sole of the foot on the well side; that is to say pressure is applied to a surface which is adapted to pressure and accustomed to it. The wing nut enables one to regulate the amount of traction to a hair's breadth. Before applying the apparatus careful measurement is taken on the well side, and as the anterior superior spinous process and the malleolus on the fractured side are exposed the measurements can be checked daily, or as often as thought necessary, and traction regulated accordingly. In children adhesive straps applied to the fractured extremity afford satisfactory traction but in adults a pin introduced through the lower end of the femur, or preferably through the tibia, at about the level of the tibial tubercule, is more efficient. By using this apparatus nearly all fractures of the shaft of the femur can be satisfactorily treated without open reduction. If crepitus is absent, operation will almost certainly be required.

### Fracture of the Neck of the Femur

The treatment of fractures of the neck of the femur is in process of rapid evolution. For nearly three decades, what is known as the Whitman abduction treatment, was that most generally used. During the last few years the Ledbetter method has found favor in many quarters and has the advantage over the Whitman method of providing what its author regards as a reliable test of satisfactory reduction. Interest in the treatment of fractures of the neck of the femur was enormously stimulated by the publication by Dr. Smith-Petersen in 1931, of a method of internal fixation by means of a three-flanged nail which he had devised. Smith-Petersen's original operation was complicated and difficult, but various modifications have been introduced which have greatly simplified the use of the three-flanged nail. A most arresting contribution to the treatment of fractures of the neck of the femur by the three-flanged nail was made in October of last year at the Clinical Congress of the American College of Surgeons by Lawson Thornton and Kelvin Sandison of Atlanta, Georgia. These authors, during a period of three years, used the three-flanged nail routinely in all the early fractures of the neck of the femur which came under their care, numbering sixty, and the results they claimed were spectacular. There were no operative deaths and no infections. No external fixation of any kind is used. The joint is not opened. The operation is performed through a small incision on the outer aspect of the thigh just below the trochanter. The reduction is effected by simply rotating the limb inward and gently abducting it, and the position of the nail as it is being driven home is verified during the course of the operation by a series of lateral and anterio-posterior X-ray pictures. The X-ray work is done in the operating room without disturbing the position of the patient. The films are over-exposed, rapidly developed in a small dark room in one corner of the operating theatre and put on the viewing box in a couple of minutes. Sitting in a wheel chair is begun on the day of the operation or the following day but no weight bearing is permitted for eight weeks when partial weight bearing with crutches is begun. It is my opinion that this method of treating fractures of the neck of the femur will be increasingly employed.

### Fractures of Forearm

Fractures of both bones of the forearm with overlapping are often extremely difficult to reduce satisfactorily by any closed method. I have frequently operated on these fractures and found the fragments so entangled in muscles that even with the fracture fully exposed, reduction was anything but easy. Very frequently these fractures are roughly transverse and the edges of the fragments are so serrated that if reduction is effected the fragments will lock securely and no form of internal fixation is required. Sometimes a small plate or an intramedullary bone graft on one bone may be required, the other being managed without any internal fixation.

In treating fractures of the olecranon process and of the patella, open reduction will usually be preferred. It is usually not difficult to expose the olecranon process, adjust the fragments, and fasten them together accurately with wire, kangaroo tendon or other suitable material. For those who prefer not to use wire or other foreign material for fastening the fragments together, an ingenious method proposed by Dr. Charles Rombold of Wichita, Kansas, may be employed. The posterior surface of the triceps is exposed for several inches and two long strips of fascia about three inches in length and a quarter of an inch wide, are raised from the back of the upper arm and dissected downwards to the region of the fracture. A transverse hole is drilled through the upper part of the ulna half an inch distal to the line of fracture, then one strip of fascia is passed from the medical to the lateral side of the other from the lateral to the medical side through this hole. The fragments are accurately adjusted and these strips of fascia are then tightly tied and sutured together. I employed this method in one case and found it very satisfactory but it is more complicated than the use of wire or kangaroo tendon.

### Fractures of the Patella

For a long time it has been generally accepted that fractures of the patella should be treated by open reduction and the various methods of fastening the fragments together with wire, kangaroo tendon, strips of fascia, bone screws, etc., have been fully described in various publications. Within the last two years, however, two papers have appeared which suggest that perhaps our ideas regarding the function of the patella and the treatment of fractures of this bone are due for revolutionary revision. In July, 1936, Dr. Wm. E. Blodgett, of Detroit, reported the results of his treatment in a considerable series of cases, in both private and public practice, by removing a portion or all of the fractured bone. He advised that where the patella is badly comminuted, the fragments should be removed; where

there was a sizeable lower fragment the proximal fragment only was removed. Results were excellent.

In April, 1937, Mr. R. Brooke, surgeon to the Royal West Sussex Hospital, Chichester, England, published an arresting paper. He advanced the view that philogeny is responsible both for the presence and development of the patella, and that there is no evidence that its development is a response to a functional need, or that the bone serves any useful purpose when it is formed. He stated that the patella is an integral part of the skeleton phylogenetically inherited. He referred to researches which show that the patella is neither situated nor devoleped in the tendon of the quadriceps but quite independently and behind the tendon, although later the tendon obtains attachments to it. He points out that "The functional activity of the quadriceps muscle in man increases on the whole from birth until adult life is reached and the relative size of the patella, if governed by function, should be proportionately larger in the adult. Actually, it is relatively smaller. The same holds in the case of the adult lion and bear. There is no relation between the depth of the patella fossa of the femur and the size of the patella or the activity of the animal. In short, there would seem to be no indication that in animals function influences the development and growth of the patella. Thus in sloths, moles and echidnae, all slowly moving animals, the bone is massive and proportionately well developed, while in the fox, deer, and leopard, all rapidly moving animals, the bone is proportionately small. Finally in the kangaroo in which the quadriceps is developed enormously in conformation to the animal's mode of progression, the bone is completely absent. In animals of the older order and in animals that are now extinct, the patella is relatively larger and more important than it is in younger members of the same family." Mr. Brooke's article describes a number of experiments by which he investigated the importance of the patella in movements of the knee joint, and he reached the conclusion that while the patella has been adapted to play a part in the movements of the knee joint, it was not designed for this purpose; that, in short, it is a morphological remnant which is tending to undergo reduction and to disappear. He even goes so far as to say that the presence of the patella is incidental and a detriment rather than an aid to the movements of the knee.

During a period of seven years he operated upon and removed the patella in thirty cases of simple fracture. The bone is removed through a vertical incision and shelled out of its aponeurotic covering. The quadriceps tendon is then carefully repaired with either interrupted silk sutures or a fascial strip. A firm bandage is applied over an ample layer of cotton wool but no other splint is used; the patient is allowed up in two days and returns to work in from two to six weeks.

The article describes a simple apparatus by which the strength of extension of the knee can be measured. Ten of his cases were submitted independent observers, the measurements we taken, and with one exception, the leg from whi the patella had been removed was actually strong than its fellow.

Mr. Ernest W. Hey-Groves of Bristol, in a sho article discussing Mr. Brooke's paper, stated th his first reaction was one of frank incredulit He asked Mr. Brooke to show him some of h cases and eight of them were submitted to h examination. He states, "It was impossible any case to detect any difference between t functional use of the injured and the uninjur leg. If the knee were covered with a banda one could not guess which had been the damag limb." He goes on to say that while convinc he was still mystified and sought the help of Pr fessor Whitnall of the Anatomical Departme of Bristol University. Professor Whitnall pr pared two specimens which explained the matte These anatomical specimens show that the qua riceps tendon merely passes over the patella become continuous with the patellar ligame below. The upper and lower margins of t patella are covered with fat and give no attac ment to any ligamentous fibres. The secon specimen showed a front view of the knee joi after the patella has been excised. Pulling the quadriceps tendon still produced extensi of the knee. "It is evident that quite apart fro those fibres of the quadriceps tendon which pa over the patella to the ligament below, there a ample fibres of the tendon present on each sid of the patella to carry on continuity. Those the medial side go partly to the patellar ligame and partly to the medial tuberosity of the tibi Those on the lateral side go partly to the patell tendon and partly to join the ilio-tibial band i serted into the lateral tuberosity. In every fra ture of the patella these lateral expansions of th quadriceps tendon are torn, and it is the sutu of these lateral expansions which is the most i portant part of the operation of repair. It clear that when the fragments of the fracture patella are removed, a much more close and fir repair can be made of the torn tendon."

## CASE REPORTS

### *Three Cases of Allergy in Children

*By*

GORDON CHOWN, B.A., M.D.

For briefness in presenting the cases, I wi detail only the family and personal history as relates to allergy.

#### First Case.

M. W., female, aged six years. The mother brother has had intractable asthma since infanc I first saw the patient at the age of six month

* Presented before the Group Luncheon Meeting, Winnip General Hospital, April 7, 1938.

with an eczema involving face, arms, legs and an urticaria confined to the anterior portion of the chest.

The mother was of the opinion that the onset of the rash was coincident with the introduction of Cream of Wheat into the baby's diet. At the age of fourteen months, the eczema had completely cleared and she has remained free from the condition to date.

I did not see the patient M. W. again until June 12, 1937. The complaint was constant cough, worse at night and a persistent nasal discharge, interfering with normal sleep.

From October until January, 1937, she had been treated by an otolaryngologist with nasal packs and a series of cold serum injections without benefit.

In January, 1936, the family physician diagnosed Pertussis, and gave a further series of injections with Pertussis Antigen, with no improvement in the condition.

On an average the patient had spent one week in bed out of every month. She had an extremely fussy appetite, with consequent loss in weight.

Examination of the chest revealed scattered rhonchi. On this basis and the allergic family history, previous eczema in the patient, a diagnosis was made of bronchial asthma and allergic rhinitis: the latter confirmed by nasal smear which showed twenty per cent. of eosinophiles.

The patient indicated by Protein tests that she was sensitive to the following animal emanations: Horse dander, Dog hair, Cattle hair, Chicken feather, Camel hair; To foods: Apple, Peanut, Wheat, Proteose, Cottonseed, Lamb, Pea, Grapefruit, Pineapple. The reaction to wheat confirms the mother's observation that the eczema appeared with the introduction of wheat in the child's diet.

About this time Dr. Lyle Montgomery, a graduate of the Manitoba Medical College, and now Pathologist at the Ball Memorial Hospital, Muncie, Indiana, arrived in Winnipeg on holiday. As a cousin of the mother of M. W. he was greatly interested and suggested that his laboratory prepare an autogenous house dust extract as a test for further sensitization. Subsequent test indicated a very positive reaction to the patient's own house dust.

Combining the house dust and positive proteins with the exception of the foods, a treatment set was prepared by Dr. Montgomery's laboratories. Desensitization was commenced August 27th, 1937, and completed November 30th, 1937. The foods were eliminated from the diet.

On Hallowe'en, the patient indulged rather too freely in apples and peanuts, and had a moderately severe attack of asthma the same evening. Other than this she has been entirely free from symptoms. She sleeps twelve hours without distress. She has an excellent appetite with the resultant gain in weight of eight pounds.

### Second Case.

The twin boys are M. W.'s brothers, J. W. and T. W., aged two and one-half years. The twins were entirely free from allergic symptoms until February 15th, 1938. Simultaneously on the same day they developed an eczema involving the back, buttocks, the flexor surfaces of the elbows and the popliteol spaces.

They sleep on their faces.

In spite of the elimination of wheat and eggs from their diet, and local applications, there is very little improvement in their condition. They are now on a diet, eliminating milk in addition. Protein tests have not been carried out. The mother is now very allergic-conscious, and is attempting on the basis of her knowledge to work out her diagnosis.

April 20th, 1938; with the elimination of milk, wheat, and eggs from the twins' diet for two weeks, the eczema has almost completely cleared.

### Third Case.

M. F., age six years, is an only child, first seen January 5th, 1938. The history of allergy is as follows: Grandfather on the father's side has had the asthma for years. Sister on mother's side, constant asthma for the last four years. She has had repeated antrum operations without benefit.

Since January, 1935, the patient has had a constant nasal discharge associated with great difficulty in breathing, snoring, and inability to go to sleep before eleven p.m., and a chronic morning cough on wakening.

September, 1937, the tonsils and adenoids were removed, with no improvement in his condition.

Physical examination was negative with the exception of the nose, which was filled with glary mucus. Nasal smear showed thirty per cent. of eosinophiles.

Protein tests, including pollens and autogenous house dust, were negative. The child has been placed on an elimination diet, but sufficient time has not elapsed to evaluate the result.

X-ray of the sinuses shows a very slight cloudiness of the right antrum, but active interference has not been advised until every effort has been completed to ascertain the explanation of his allergy.

The first and third cases illustrate the value of a nasal smear in the differential diagnosis of allergic and infective rhinitis.

In conclusion, some physicians argue that adult asthma is largely psychological, and can be successfully treated along these lines, but the argument does not apply to children, whose greatest happiness in life is the "joy of living." Children of this age group have no hidden complexes or emotional upsets of such intensity as to cause them to develop a shelter complex in the form of asthma or other allergic syndromes.

# Special Articles and Association Notes


## The Manitoba Medical Association Review

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## Minutes of Executive Meeting

Minutes of a regular meeting of the Executive of the Manitoba Medical Association held in the Medical Arts Club on Friday, April 8th, 1938, at 6.30 p.m.

**Present.**

Officers and Members of Executive—

| | |
|---|---|
| Dr. C. W. Burns (Chairman) | Dr. O. C. Trainor |
| Dr. E. S. Moorhead | Dr. W. W. Musgrove |
| Dr. A. S. Kobrinsky | Dr. E. L. Ross |
| Dr. S. G. Herbert | Dr. D. J. Fraser |
| Dr. E. K. Cunningham | Dr. W. S. Peters |
| Dr. W. G. Campbell | Dr. W. H. Clark |
| Dr. J. R. Martin | Dr. C. W. MacCharles. |

Chairmen of Committees—

Dr. J. D. McQueen (committee on maternal mortality), Dr. F. D. McKenty (committee on federation).

Following dinner, the President called the meeting to order at 7.30 p.m.

The Secretary reported there were four special meetings held since the last regular meeting and that the minutes of each having been published in the *Review*, asked if the meeting desired these to be read.

It was moved by Dr. E. S. Moorhead, seconded by Dr. D. J. Fraser: THAT these minutes as recorded be taken as read, and adopted. —Carried.

**Federation.**

Report by chairman of committee on Federation (Dr. F. D. McKenty).

Copies of the report of the Committee on Federation were distributed among the members. The report is as follows:

"The Committee on Federation of the Manitoba Medical Association in accordance with the instructions of the Executive to report upon the new draft for a constitution for a federated Canadian Medical Association, beg to submit the following:

No copies of the proposed constitution have been available. The only information regarding it that the Committee has obtained was from the reading of selected passages by the General Secretary of the Canadian Medical Association at the recent informal meeting with the Manitoba Medical Association Executive. This was not sufficient to warrant any definite report upon the details. Your Committee can therefore only reiterate the conclusions and resolutions already reached by the Manitoba Medical Association upon the Federation Proposal.

The Manitoba Medical Association has declared itself in favor of a Federation that meets certain requirements. These may be briefly summarized as follows:

The function of the federated body should be limited to the fields in which the need for centralized action can be clearly shown, and these fields should be defined.

The mandatory body must be fully representative of the whole medical profession.

The general policies of the federated body should be subject to discussion by the general profession and approval or otherwise, registered through the constituent representatives.

Avenues for the prompt expression of the views of any section of the membership should be provided and kept open, and information regarding the proceedings should be fully and regularly supplied to the membership.

The membership of the mandatory body should be as small as is consistent with full representation. (The present General Council is much too large). Active membership should be conditional upon attendance at the sessions. Active members should be representative of their constituents and instructed in advance of the session upon the matters to be decided. An accredited substitute should be named for each active member. (See procedure of B.M.A.). (In order to secure the above conditions it may be necessary for the federated body, or its constituent sections, to assume a portion of the necessary expense).

The Executive must also be fully representative. The responsibility of each member of the Executive should be directly to the constituent association which he represents.

Each member of the Executive should be instructed by his association (or division) before each session of the Executive, upon the matters in the agenda which concern it, and he should report to it the decisions which have been reached.

The general aim of the foregoing provisions is to secure a federated body that will be to the fullest possible degree representative of and responsive to its membership. Under such conditions the responsible management would be at all times aware of the degree of professional support it enlisted, and leadership could be assured and progressive.

It is recognized that a fully representative procedure is of necessity slow and troublesome, and that it would entail some publicity of the business of the association. However, rapid decisions in matters of policy are rarely necessary, and the secrecy of the Board of Directors of an industrial corporation should be needless and out of place in a body representing a liberal profession. Only the moral support involved in a thoroughly representative procedure can enable the management to speak with authority for the whole profession. Your Committee firmly believes that the ultimate value of any Federation depends upon the degree to which such character is maintained.

Although no decision has been reached on this, the general trend of the discussion indicated approval of the foregoing."

The Chairman asked Dr. McKenty if he could show where the new constitution fell short of the principles desired by the Manitoba Medical Association. Dr. McKenty pointed out that no copy of the constitution had been received by the Manitoba Medical Association, and that it had not been discussed in detail. The only copies available had been borrowed from Dr. Moorhead and Dr. Fahrni.

The Chairman then renewed the history of the negotiations with the Canadian Medical Association, including the visits of the President and the Secretary of the Canadian Medical Association.

Dr. Musgrove asked why the Executive Committee should consider this proposed constitution, as no copy had been sent to the Manitoba Medical Association.

Dr. McKenty explained that there were two Committees on Federation, one of the Canadian Medical Association of which Dr. Fahrni was a member, but was appointed by Toronto, and the other the Manitoba Medical Association Committee on Federation of which Dr. F. D. McKenty is Chairman.

Dr. McKenty then discussed the principles referred to in the report and pointed out that an examination of the prepared constitution of the Canadian Medical Association showed that these principles were not embodied in the draft.

Dr. McQueen wanted to know how the executive committee could pass on the constitution when they have not received a copy of the draft.

The Secretary then read extract from minutes of a special meeting of the Executive held on March 11th, 1938, page 0555, with regard to this.

Dr. McKenty stated that the more he considered this problem the more he gained the impression that those who are responsible for promoting this proposal seem to be unable to grasp the true meaning of federation. What is being attempted is to extend the authority of the Canadian Medical Association over the Provincial Associations. He explained that federation meant a voluntary union between previously existing free bodies.

Dr. Trainor stated that he assumed that this draft of the constitution of the Canadian Medical Association is coming up for final ratification in June, and wished to know what attitude the Manitoba Medical Association is going to take and if they are to make recommendations.

Dr. Burns proposed we should write to them along these lines indicated in the discussion. We have a copy of the proposed constitution and could make additional copies and distribute them to the Executive. Dr. Burns further suggested that Dr. Moorhead should take a copy of Dr. McKenty's report with him.

Dr. Trainor was of the opinion that the Committee's report is not sufficient. It is too much on general terms but might be taken as an interim suggestion. It is not a final report. We should be prepared to offer constructive ideas.

Dr. Moorhead suggested this report should be made known to the Executive of the Canadian Medical Association.

Dr. Trainor stated we must know on what basis we are prepared to accept federation, and should be prepared to state what we are willing to accept.

Dr. Musgrove insisted that if the Canadian Medical Association are not prepared to take us into their confidence, the profession will never work harmoniously across Canada.

Dr. Martin asked if there was a chance of getting a cross section of opinion in Manitoba before June. It was suggested that this could be done through the District Societies.

Dr. Burns stated that we could tell the Canadian Medical Association at the meeting in June that we were not ready.

Dr. Trainor asked if we would be required in June to ratify this constitution and federation.

Dr. McKenty stated that no one could put us in federation except ourselves, and advised what we are facing is a treaty with the other provinces and not the Canadian Medical Association. Technically and legally what is required is a conference of the provinces. But once we were in federation it would be difficult to escape again. This matter could be dealt with only at the annual meeting of the Manitoba Medical Association, in September.

It was moved by Dr. W. W. Musgrove, seconded by Dr. E. K. Cunningham: THAT this report be tabled.

Dr. Moorhead advised that he thought that we should express some opinion as our silence might be interpreted as meaning consent. This opinion

was discussed at length. Dr. Musgrove eventually withdrew his motion.

It was moved by Dr. O. C. Trainor, seconded by Dr. W. S. Peters: THAT we accept the interim report of the Committee on Federation, and that we instruct our representative on the Canadian Medical Association Executive, Dr. E. S. Moorhead, to present this report to the Canadian Medical Association Executive, and to indicate to them that the Executive of the Manitoba Medical Association does not feel that the principles as contained therein are fully embodied in the present draft of the constitution of the Canadian Medical Association, and that the Committee are further considering the constitution in detail, and

THAT the Secretary of the Manitoba Medical Association be directed to have copies of the proposed constitution of the Canadian Medical Association mimeographed and sent to all members of the Executive. —Carried.

**Organization of a National Society for the Control of Cancer and the King George V. Silver Jubilee Cancer Fund.**

The Secretary read a motion, page 0547, in which he was instructed to write to the General Secretary of the Canadian Medical Association asking for information with regard to the amount of the King George V. Silver Jubilee Cancer Fund and the interest available each year, and the proposed method of spending the money. The Secretary then advised that a letter had been written to Dr. Routley asking for information regarding these several points. A reply was received from Dr. Routley dated December 31st, 1937, answering these questions, which was read by the Secretary.

Dr. Routley attended a meeting of the Manitoba Medical Association on March 11th, minutes of which were read by the Secretary to the meeting.

The Secretary attended a meeting of the medical members of the Cancer Relief and Research Institute, including Dr. P. A. MacDonald the physicist, in the Medical Arts Club on March 11th, 1938, at which Dr. Routley was present. A summary of the proceedings had been prepared by the Secretary after the meeting of the Institute and this was read:

> The members of the Institute were anxious to know how the proposed National Committee for the Control of Cancer would effect the revenue of the Manitoba Institute. It was pointed out that if a national tag day were established to secure funds for control of cancer, that it was probable the Federated Budget and the Winnipeg Foundation would withdraw their grant from the Manitoba Institute. Dr. Routley advised that definite plans for this had not yet been made, and that it should be possible to urge the organizations concerned to continue their grants until such a time as the National Body would be able to finance the Manitoba Institute.
>
> The question of the King George V. Silver Jubilee Cancer Fund was then discussed. Dr. M. R. MacCharles asked if this fund was to be handed over to the National Society for the Control of Cancer. Dr. Routley explained that the Trustees of the King George V. Silver Jubilee Cancer Fund had asked the Canadian Medical Association to do two things: first, to set up a National Society for the Control of Cancer; and second, to provide for the disbursement of the revenue from the King George V. Silver Jubilee Cancer Fund.
>
> The Canadian Medical Association had arranged for the setting up of the National Society for the Control of Cancer, and a charter was being issued at Ottawa. The King George V. Silver Jubilee Cancer Fund would not be given over to this Society, but would be retained by the Canadian Medical Association for its own work in connection with cancer. The capital would not be used, but the yearly revenue would be used to pay for speakers on cancer at medical meetings, for publications on cancer, and education of the medical profession generally with regard to cancer.
>
> **National Society for the Control of Cancer.** Dr. Routley explained that under the charter there would be a Grand Council of eighteen members, two from each province, one of whom would be a layman and one a medical man. This Grand Council would then hold a meeting in Ottawa or Toronto and organize a Society. Memberships in the Society would then be obtained by people who gave grants of money.
>
> **The Activities of the Canadian Medical Association Committee on Cancer.** Dr. Routley explained that these were to include the sending out of speakers on cancer to various medical meetings, the setting up of cancer study groups in all hospitals of fifty beds or over, and the publication of a book on cancer. He stated that chapters of this book had been prepared and sent out to the nine medical schools in Canada, in order that each chapter could be criticized. He stated that they had been well considered by the various medical schools and that the criticism from Manitoba had been very searching. It was suggested by various members of the Institute that this book might be of doubtful value.

A motion was passed with regard to method of spending revenue from the King George V. Cancer Fund. The Secretary was instructed to send a copy to the Canadian Medical Association.

**Communication.**

The Secretary read a communication from Dr. J. M. McGillivray dated March 23rd, 1938, referring to an item in the March issue of the *Review* under the heading of Unethical Rebates. In order to familiarize the members with this matter, Dr. Burns reviewed the question from the beginning.

Dr. W. G. Campbell gave a lengthy address to the meeting outlining the discussion of this subject at the College of Physicians and Surgeons' meeting, and that they were prepared to investigate any specific cases that were presented. He stated that this question was far reaching and that it also included the cases of general practitioners who were alleged to be receiving rebates from surgical houses for trusses, abdominal belts, etc.

Dr. McQueen suggested that this should be made known definitely to the younger men, that to accept credits or rebates is strictly unethical.

Dr. Trainor advised that this came up before the Executive of the Winnipeg Medical Society and they considered that the proper body to advise

the profession was the College of Physicians and Surgeons, and that they had also been requested to obtain legal advice as to whether rebates are an offence against the criminal code.

It was moved by Dr. J. R. Martin, seconded by Dr. W. G. Campbell: THAT the action of the Special Meeting of the Executive in referring the matter of rebates to the College of Physicians and Surgeons, and the publication of this minute in the Manitoba Medical Association *Review,* be approved by the full meeting of the Executive. —Carried.

**Letter from Dr. Strong Re. Workmen's Compensation Board.**

The Secretary reviewed the correspondence in connection with this subject.

Following further discussion, it was moved by Dr. S. G. Herbert, seconded by Dr. W. S. Peters: THAT as this matter appeared to be of deep concern to Dr. Strong we should go a step further and the Committee should arrange a meeting with Major Newcombe at a definite time, and Dr. Strong be present at this meeting in his capacity as a member of the Committee. —Carried.

**Report of Committee on the Distribution of Pamphlets on "Suggestions for Feeding the Baby from 9 to 12 Months of Age."**

The Secretary read report signed by Dr. Wheeler as Chairman of this Committee dated January 21st. The report is as follows:

"A meeting has been held by your Committee appointed at the Executive meeting of November 23rd, 1937, for the study of Public Health Pamphlets. Dr. Kobrinsky and Dr. Wheeler were present; Dr. Gordon Chown was there by invitation. The following are our observations:

1. There is decided re-duplication in the publication and distribution of these Public Health Pamphlets. Apparently all of the books are available through the Central Council of Social Agencies at Ottawa. This Council has offered to distribute these pamphlets or books to the different governments.

2. Regarding the distribution in Manitoba:

These books should be distributed only directly to the people in unorganized districts. In those districts where there is a medical man, and the Department of Public Health has received a request for a book for a patient in his area, the Government should refer this patient to the local doctor. He should have these pamphlets forwarded to him for distribution by the Department of Public Health."

It was moved by Dr. A. S. Kobrinsky, seconded by Dr. D. G. Fraser: THAT this recommendation be endorsed. —Carried.

**Pregnancy Survey in Manitoba.**

Dr. McQueen addressed the meeting on this subject and advised that the Canadian Medical Association had been asked to donate to the fund which will be available for distribution to the physicians in Manitoba for filling out pregnancy reports, an amount equal to that guaranteed by the Manitoba Medical Association, and he believed this was $2,000.00. He stated Dr. Routley was in sympathy but thought it advisable if this came through the Manitoba Medical Association. He requested that this body recommend to the Canadian Medical Association the request of their own Committee by granting a donation to the survey in Manitoba equal to that guaranteed by the Manitoba Medical. This fund is not to be used in any way for administration. The Maternal Welfare Committee felt that it would be unfair to ask physicians to fill in these reports without some remuneration.

It was moved by Dr. J. D. McQueen, seconded by Dr. E. S. Moorhead: THAT the Executive Committee of the Manitoba Medical Association recommend that the Canadian Medical Association should grant a sum of money for the payment of doctors completing the returns for the pregnancy survey in Manitoba, and that this sum should be equal to that guaranteed by the Manitoba Medical Association, namely, two thousand ($2,000.00) dollars. —Carried

Dr. Burns explained the circumstances regarding this guarantee. Dr. Campbell advised that he expected this payment would be forthcoming from the College of Physicians and Surgeons.

It was moved by Dr. W. S. Peters, seconded by Dr. D. J. Fraser: THAT the full Executive Committee approve of the action of the special meeting of the Executive in regard to this guarantee. —Carried

**Correspondence from Associated Medical Services and Kingston General Hospital.**

As this subject was too lengthy to discuss at this meeting, it was left for further consideration. The Secretary advised that he hoped to prepare a summary of these plans.

**Consideration of Agenda of C.M.A. Meeting, April 15th and 16th.**

Dr. Moorhead asked for instructions with regard to various items on the agenda of the executive committee meeting of the Canadian Medical Association. These were discussed in detail and instructions given.

*Committee on Economics.*

Dr. Moorhead read communication received from Dr. Wallace Wilson, Chairman of the Canadian Medical Association Committee on Economics, and he asked approval of his drafted reply. This was approved.

**Group Hospital Insurance.**

The Secretary reported he had attended a meeting of the Central Council of Social Agencies on April 4th, at which Mr. E. A. Van Steenwyk was invited to speak to the Council on the Minnesota Scheme of Group Hospital Insurance. Copy of the secretary's report is on file.

Dr. Trainor and Dr. Moorhead discussed this plan.

**Membership in the Manitoba Medical Association.**

The Secretary reported on the paid memberships in the Association to date, and the results of the new method of collecting fees. He explained the difficulty was that a motion had been passed at a previous Annual Meeting in which back dues were to be charged, but that it was found impossible to do this, and that this year applications for membership had been mailed out to non-members and bills sent to the members.

It was moved by Dr. W. S. Peters, seconded by Dr. E. L. Ross: THAT the Executive Committee endorse the action of the officers in this respect. —Carried.

**Annual Meeting of Manitoba Medical Association.**

Discussion followed as to the date of the Manitoba Medical Annual Meeting, and whether the dates would conflict with the North Western and Brandon District meeting to be held at Clear Lake. This is to be arranged accordingly.

It was moved by Dr. O. C. Trainor, seconded by Dr. E. K. Cunningham: THAT Dr. Digby Wheeler be Chairman of the Programme Committee, and Dr. F. G. McGuinness be asked to act with him, with power to add to their number if necessary. —Carried.

It was moved by Dr. E. L. Ross, seconded by Dr. D. J. Fraser: THAT the appointment of the balance of the Committees in connection with the Annual Meeting be left to the officers. —Carried.

**Correspondence.**

**Letter from Winnipeg Medical Society embodying resolution passed by the Staff of the Misericordia Hospital.** Letter was read from the Secretary of Staff of the Misericordia Hospital with regard to reports made to insurance companies, asking that the consent of the patient to give such information should be obtained, and that a uniform fee of $3.00 be charged.

It was moved by Dr. E. W. Stewart, seconded by Dr. S. G. Herbert: THAT this Executive approve of the resolution, and the matter be referred to the Canadian Medical Association for their information and necessary action. —Carried.

**Letter from Winnipeg Medical Society Re. Radio Broadcasting Sponsored by Chiropractors, Opticians, Sanitoria for Alcoholics, etc.** This communication was read to the Executive, and the Secretary reported he had replied to this letter asking for further details as to the particular sanitorium referred to, but to date no answer has been received.

It was moved by Dr. D. J. Fraser, seconded by Dr. S. G. Herbert: THAT this should be referred to the Department of Health as the circumstances in question come under the jurisdiction of the Provincial Government, and Dr. R. W. Richardson as Chairman of the Radio Committee be requested to do this. —Carried.

Dr. Peters stated that there was a programme of the American Medical Association broadcasted over the network at 1.00 a.m., which was an excellent one and well worth listening to, and he asked if it would not be possible to obtain a similar programme on the C.B.C.

This matter is to be brought to the attention of Dr. Richardson and Dr. Moorhead, should it be possible for Dr. Moorhead to bring it up at the Canadian Medical meeting.

Letter was read from Dr. R. Bier regarding the cancellation of church services over C.K.Y. and C.B.C.

It was moved by Dr. W. G. Campbell, seconded by Dr. D. J. Fraser: THAT a letter be written to C.K.Y. asking if this service could not be reinstated. —Carried.

**Canadian Medical Institute Examinations.** Letter from Dr. Goodwin was read advising that the Canadian Medical Institute had forwarded to a patient a list of physicians to whom this man might apply for periodic health examinations. It was stated that Dr. Routley had already advised the association that now patients had the right to choose their doctor, and that this was indicated on the form.

**Re. Travelling Expenses.**

Dr. Fraser brought up the question of travelling expenses for members of the Executive coming in from the country, and it was pointed out that this had been authorized sometime ago and some members rendered accounts while others never did so. It was felt that this should be made a uniform procedure. Following discussion it was decided that transportation charges, berths and hotel bills with a limit of $3.00 per day for hotel, might be rendered and will be paid by the Association.

The meeting then adjourned.

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# Department of Health and Public Welfare

NEWS ITEMS

## MENTAL HYGIENE DURING THE FIRST TWO YEARS OF LIFE

LEO KANNER
Associate Professor of Psychiatry
the Johns Hopkins Hospital

Rarely do infants require psychiatric attention. General practitioners and pediatricians have the decided advantage over psychiatrists in that they are called not only to treat sick babies but also to prevent illness through special methods (Credé procedure, immunization, regulation of feeding, etc.) and through education of the parents. This education usually extends to matters of physical health only. Yet there is a great opportunity for the family physician to include mental hygiene as well in his prophylactic interests. In fact, he is the only person to whom this opportunity offers itself from the very beginning of a child's life.

Physicians and the general public have rightly become accustomed to give considerable breadth to the concept of physical hygiene. Its implications, based on medical discoveries and insights, have come to encompass a wide range of measures in physicians' offices, hospitals, homes, schools, factories, city administrations and country governments. Its goal has been broadened from attempts to forestall certain epidemic diseases to a vast program of health preservation. Similarly mental hygiene, emerging from psychiatric and psychological realizations, has during the past few decades widened its scope far beyond the original idea of wanting to prevent "insanity and delinquency." Its messages and methods are penetrating the fields of family life, education, jurisprudence, industry, general medical practice and the early training of children. It works towards a person's satisfactory adjustment to the environment and also towards a satisfactory environment to which a person can reasonably be expected to adjust.

The interrelationship between an individual and his surroundings begins on the very first day of life and keeps increasing in variety and complexity. During the first two years, the progressive unfolding of the inherent potentialities of the species transforms the infant from a passive, helpless, inarticulate being into a more and more differentiated little participant who walks, feeds himself, controls his eliminative functions, comprehends gestures and spoken language, forms words and short sentences, and becomes an active somebody to be reckoned with. Some of this unfolding comes from within; growth, locomotion, the formation of vowels and consonants are in the main independent of educational efforts. The chief danger to the normal progress of these functions lies in hazards to bodily health. The ancient adage, Mens sana in corpore sano, still holds true. Attention to physical well-being is therefore one of the principal pillars of mental hygiene. The direction taken by the development of many other functions depends to a much larger extent on the molding forces of the infant's environment, that is, the influences of his home. Hence the considerations implied in the slogan, Mens sana in domo sana, constitute the second pillar of the mental hygiene of infancy and childhood.

Child training works towards socialization, for which the groundwork is laid at the beginning of life. Adequate socialization hinges on the establishment of relative self-dependence, security and conformity. The family physician, through his knowledge of the home and the confidence invested in him, can contribute a lion's share to the smooth introduction and maintenance of these features. As the parents' natural adviser consulted in all matters pertaining to the infant's health, he is in a strategic position that allows him to guard somatic developments, supervise home training and inculcate sound attitudes.

The job of being a parent has in recent years become beset with many perplexities. This "century of the child" has witnessed a tremendous upward surge of pediatrics and child psychology. Early gropings and controversies about infant nutrition, ideal weight charts, B.M.R., I.Q. and so-called repression have been seized upon by press and radio to haunt mothers with pseudo-scientific alarms and agitations, presented to a defenseless public as the last word in science. Many women nowadays come to matrimony and motherhood from the ranks of teachers, nurses, stenographers, salesgirls and factory workers, often with a marked tendency to thrust upon their offspring all the energies released by the abandonment of their jobs. The general unrest and insecurity of the age, the greater frequency of parental separations after hasty trials, the depression-born reversals to the custom of living with in-laws after marriage, all these factors may profoundly affect from the beginning the environmental influences upon an infant. Uninformed, misinformed, worried, scared, harassed parents, especially mothers, now more than ever before, are turning to their physicians for information, certainty and guidance.

The development of self-dependence is hampered by parental overindulgence and oversolicitude, the behavior commonly alluded to as "spoiling." Spoiling is made up of feelings and actions representing parental needs that may arise from various sources, such as the preceding death of a child, economic, marital or health features precluding the birth of other children, the void created by the substitution of unsatisfying housework for the richness of a previous social or vocational life, overcompensation for the displeasure accompanying the arrival of an unwanted child, or memories of an unhappy childhood resulting in a desire to smother the child with excessive coddling and protection. A mixture of anxiety, puzzlement, impatience and inexperience centers the family's attention on the infant's nutrition, sleep and elimination. Weaning from the breast and the bottle is delayed. The child is not given an opportunity to learn how to feed himself. The meals become tragicomic events with coaxing, cajoling, threatening and bribing by the adults and refusal, gagging and even vomiting on the part of the child. Learning how to sleep through a whole night is made impossible by the parents' habit of jumping up at the infants' slightest whimpering, carrying him about the room or rocking his cradle. Bowel overconcern resorts to purgatives, suppositories and enemas. The child, not left alone for a minute of his waking time, fondled and handled and shown off incessantly, does not have a chance to develop the socializing responsibilties commensurate with his age and remains physically and emotionally over-dependent on his elders. The well-known spoiled infant syndrome of anorexia, insomnia, constipation and attention-getting intrenches itself more and more firmly. This failure to establish a reasonable degree of self-dependence, if continued unabated, may lead in pre-school age, during the school years, and even later to disturbing difficulties of adjustment.

The development of security may at an early age be interfered with by inconsistencies in the display of affection and recognition of achievement, emphasis on real or anticipated shortcomings, instillation of fear and confusion regarding authority. The average sensibly managed infant is happy and secure and as yet untroubled by "the slings and arrows of outrageous fortune." As the temperature of his baths which should

be neither too hot nor too cold, so that of parental affection normally steers clear of the extremes of explosive demonstrativeness and chilly rebuff. Approval of success and encouragement in the face of occasional failure during the first attempts at walking, talking self-feeding, handling breakable objects, meeting strangers, etc., help to impart to the infant a sense of progress and self-confidence when confronted with ever new tasks. But sometimes parental frustrations, overambition, overconscientiousness or resentment of the child training duties as annoying inconvenience lead to sternness, perfectionism, fault-finding, undeserved punishments and nagging which make the child uncertain of himself and instill timidity, dread of his elders and lack of self-assertion. The infant is being "lectured to" and "reasoned with" in terms which he does not and cannot comprehend and is then reprimanded for "disobedience" if the sermon has had no results. Constant "corrections" of initial hesitation in reporting his experiences with an as yet inadequate vocabulary may cause him to become speech conscious and start him on the road to stuttering. The parents' dissatisfaction with his lefthandedness may make him miserable by their methods of enforcing a change of handedness. Their agitations about his thumbsucking or touching his genitals may fetter him with all sorts of mechanical devices. Beating, bogey man threats and the custom of locking him in a dark closet "for punishment" may introduce strong and disturbing fears. Under such conditions an infant cannot possibly be expected to develop a healthy sense of security. This is made even more difficult by the frequent inconsistency with which the same act, dependent on the mood of the moment, is tolerated at one time and severely rebuked at another. Besides, differences in the temperaments and attitudes of the parents and other adults in the household often create in the child a confusion of authority when the same behavior is condoned by some and turned into a great issue and censured by others.

The development of conformity depends mainly on the introduction of conventional manners, emotional control and a give-and-take attitude. The first two years are the best time to train ("condition," if you wish) a child for habit regularity. Setting certain times for the meals and, in the second year, naps and night rest and the use of the toilet offer the earliest opportunities for the establishment of routine, which is often hindered by parental overindulgence, laissez faire negligence or peculiar pseudo-medical notions that turn an infant into the central object of his mother's hypochondriasis. The latter is often fostered by fear of inheritance of some relative's disease, superstitions about prenatal "marking" of the baby, difficult labor or birth or some early illness. The child, branded as sickly, frail and delicate, receives a considerable amount of overprotection and is suspended from all reciprocal obligations. On the theory that sickly children should never be crossed, he is suffered to dominate the family, take toys away from his siblings and playmates, provided that he is allowed to have playmates, refuse violently to let them play with his own toys, eat, sleep and soil himself whenever he pleases and destroy anything he wishes to destroy. Improper adult example renders him even more unmanaged and unmanageable. It is a fact that infantile breathholding spells and temper tantrums are staged mostly in homes where unchecked emotional outbursts are common occurrences and the infant's own upheavals are met with yelling, hitting, and the dreadful habit of emptying a pitcher of cold water over him. The strange combination of giving in, screaming, spanking and faulty habit training prevents the establishment in the infant of conformity, that is, good manners, sensible use of his emotional equipment and sharing.

The family physician can help parents considerably in the mental hygiene of their children by trying to understand, inform and reassure them. He will not attain this purpose by blaming and scolding them and telling them in a general way not to pamper, worry about or be impatient with their offspring. The desire to understand implies listening to what the parents have to say. An attentive ear will not fail to get the preoccupations, concerns, solicitudes, frustrations and erroneous beliefs underlying unhealthy management and training. The average mother wants and needs enlightenment about the child's state of health, about what to expect and not to expect of him at a given age, about what to do and how to do it and what not to do. She requires specific instruction about his feeding, weight, sleep, elimination, teething, speech development, play, rest, crying, temper, fingersucking, head rolling, breathholding, restlessness or whatever else disturbs her. Nowadays a physician has to do a great deal of "unscaring" of mothers who have been frightened by current popular literature, the lingo of ill-digested psychological theories, broadcasts advertising laxatives or food products, or a grandmother's or neighbor's superstitions. Mothers need repeated reassurance that a mild illness or behavior problem does not spell lifelong doom, and advice and guidance in the task of remedying the little annoying difficulties incidental to a child's development. They equally need guidance in cases of major sickness over and above the necessary physical care.

Herein lies a great challenge to the modern physician who is the only person privileged to administer mental hygiene during the first two years of life and steer the child in the direction of self-dependence, security and conformity, in other words, in the direction of adequate socialization and good mental health.

## COMMUNICABLE DISEASES REPORTED

**Urban and Rural - March, 1938.**

**Mumps:** Total 692—Brandon 511, Winnipeg 122, St. James 12, Unorganized 6, Ethelbert 6, St. Vital 4, Virden 2, Arthur 1, Fort Garry 1, Lac du Bonnet 1, Morris Rural 1, Pipestone 1, St. Boniface 1, Whitehead 1 (Late Reported: February, Brandon 20, Unorganized 2).

**Chickenpox:** Total 205—Winnipeg 175, Kildonan West 6, Kildonan East 4, St. Vital 3, Tuxedo 3, Kildonan North 2, Argyle 1, Clanwilliam 1, Desalaberry 1, Selkirk 1, The Pas 1, Unorganized 1 (Late Reported: February, Unorganized 4, Cypress North 1, Strathclair 1).

**Scarlet Fever:** Total 90—Winnipeg 17, Brandon 12, Whitemouth 5, Arthur 4, Edward 4, Springfield 4, Flin Flon 2, Cypress North 1, Fort Garry 1, Hanover 1, Melita 1, Morden 1, Portage City 1, St. Anne 1, St. Vital 1, Unorganized 1 (Late Reported: February, Lac du Bonnet 13, Beausejour 8, Arthur 2, Edward 2, Whitehead 2, Springfield 2, Albert 1, Elton 1, Flin Flon 1, Minitonas 1).

**Whooping Cough:** Total 73—Brandon 27, Flin Flon 16, Emerson 5, Hanover 2, Unorganized 3, Morris Town 2, St. Vital 2, Kildonan East 1, Kildonan West 1, LaBroquerie 1, Winnipeg 7 (Late Reported: January, Brooklands 2, Carberry Town 1, St. Laurent 1; February, Brandon 2).

**Tuberculosis:** Total 29—Winnipeg 11, St. Boniface 3, Brokenhead 1, Brooklands 1, Lac du Bonnet 1, Lorne 1, Ritchot 1, Roland 1, Shell River 1, Strathcona 1, Strathclair 1, St. Clements 1, St. Paul 1, Tuxedo 1, Unorganized 1, Whitemouth 1 (Late Reported: February, Brandon 1).

**Erysipelas:** Total 13—Winnipeg 7, St. James 2, Hanover 1, Minitonas 1, St. Anne 1 (Late Reported: January, Strathcona 1).

**Influenza:** Total 13—Winnipeg 2 (Late Reported: January, Brandon 2, Cartier 2, Edward 2, Archie 1, Louise 1, Norfolk South 1, St. Vital 1, Unorganized 1).

**Measles:** Total 12—Emerson 3, Thompson 1, Unorganized 1, Winnipeg 1, Portage City 1 (Late Reported: February, Portage City 3, Brandon 1, Shell River 1).

**Diphtheria:** Total 7—Winnipeg 6, St. Boniface 1.

**Typhoid Fever:** Total 5, Portage Rural 1, St. Anne 1, Unorganized 1 (Late Reported: January, Unorganized 2).

**German Measles:** Total 3, Sifton 2 (Late Reported: February, Pipestone 1).

**Anterior Poliomyelitis:** Total 1, Winnipeg 1.

**Cerebrospinal Meningitis:** Total 1—Tuxedo 1.

**Puerperal Fever:** Total 1—LaBroquerie 1.

**Trachoma:** Total 1—St. Paul East 1.

**Venereal Diseases:** Total 97—Gonorrhoea 63, Syphilis 34.

### DEATHS FROM ALL CAUSES IN MANITOBA
**For the Month of February, 1938.**

URBAN—Cancer 32, Pneumonia 13, Influenza 5, Tuberculosis 5, Syphilis 2, Lethargic Encephalitis 1, Scarlet Fever 1, Whooping Cough 1, all others under 1 year 8, all other causes 115, Stillbirths 16. Total 199.

RURAL—Pneumonia 21, Cancer 18, Influenza 9, Tuberculosis 9, Scarlet Fever 2, Lethargic Encephalitis 1, Erysipelas 1, Whooping Cough 1, Syphilis 2, all others under 1 year 27, all other causes 103, Stillbirths 8. Total 202.

INDIAN—Tuberculosis 9, Pneumonia 6, Influenza 1, Cancer 1, all others under 1 year 6, all other causes 9, Stillbirths 0. Total 32.

## Medical Library
## University of Manitoba

### Current Medical Literature

**"The British Journal of Surgery"—January, 1938.**

"The Evolution and Development of Surgical Instruments," by C. J. S. Thompson, M.B.E., Ph.D., Hon. Curator of the Historical Collection, Museum of the Royal College of Surgeons of England.

"Vascular Endothelioma of the Lung," by A. Tudor Edwards, Surgeon-in-Charge, Department of Thoracic Surgery, London Hospital; Surgeon, Brompton Hospital; and A. Brian Taylor, Assistant Physician, Queen's Hospital, Birmingham, Late Resident Surgical Officer, Brompton Hospital.

"Right 'Duodenal' Hernia," by Milroy Paul, Professor of Surgery, Ceylon Medical College, Surgeon to the General Hospital and the Lady Ridgeway Hospital for Children, Colombo; and W. C. Osman Hill, Professor of Anatomy, Ceylon Medical College.

"Two Cases of Congenital Microcolon," by J. B. Ewing and W. E. Cooke, Wigan.

"Chronic Regional Colitis," by T. G. Illtyd James, London.

"Acute Regional Ileitis: A Report of Two Cases, with Bacteriological Findings," by Robert Mailer, Assistant Surgeon, Victoria Infirmary, Glasgow.

"On Chronic Inflammatory 'Tumours' of the Gastro-Intestinal Tract," by F. G. Ralphs, Ashton-Under-Lyne.

"Crohn's Disease, or Regional Ileitis," by Sir Lancelot Barrington-Ward and R. E. Norrish, Royal Northern Hospital.

"Brain Abscess," by Gilbert Horrax, Boston.
"Torsion of the Testicle and of the Hydatid of Morgagni," by J. Lambert, Medical Officer, Wellington College; and R. E. Smith, Medical Officer, Rugby School.
"The Surgery of the Pineal Organ," by Cecil P. G. Wakeley, London.
"Fractures of the Shaft of the Femur: A New Method of Traction and Immobilization," by Eric L. Farquharson, Tutor in Clinical Surgery, Royal Infirmary, Edinburgh.
"Pneumatocele Capitis," by J. B. G. Muir, Tongshan, North China.
"Recurrent Intussesception of the Jejunum," by William Gissane, St. James' Hospital, London.
"Latent Carcinoma of the Prostate," by D. McGavin, Surgical Chief Assistant, St. Bartholomew's Hospital.
"Interlocked Articular Processes Complicating Fracture-Dislocation of the Spine: A Survey of Some Recent Cases Treated by Open Operation," by Alan H. G. Munro, Junior Surgical Registrar, Royal Victoria Infirmary, Newcastle-Upon-Tyne. Foreword, by C. Gordon Irwin, Hon. Orthopaedic Surgeon, Royal Victoria Infirmary, Newcastle-Upon-Tyne.
"Fractured Lumbar Spine with Unilateral Dislocation," by A. Wilfrid Adams, Bristol.
"Fracture of the Os Calcis," by W. J. Eastwood, Liverpool.
"Critical Review: Malignant Disease of the Large Intestine," by Sir John Fraser, K.C.V.O., M.C., Surgeon in His Majesty's Medical Household in Scotland Regius Professor of Clinical Surgery, University of Edinburgh Surgeon, Royal Infirmary, Edinburgh.

**"Clinical Journal"—March, 1938.**

"Threatened Gangrene," by Sir John Fraser, K.C.V.O., M.C., F.R.C.S., Ed., Regius Professor of Clinical Surgery, University of Edinburgh.
"The Post-Operative Treatment of the Acute Abdomen," by G. T. Mullally, M.C., M.S., F.R.C.S., Surgeon, Westminster Hospital.
"Genital Prolapse," by Everard Williams, M.D., Camb., M.R.C.P., Lond., Obstetric Physician, Charing Cross Hospital.
"Organic or Functional?" by S. Barton Hall, M.D., D.P.M., Honorary Psychiatrist, Liverpool Royal Infirmary.
"A Case of Full-Term Ectopic Pregnancy," by E. A. Gerrard, M.D., M.C.O.G., Honorary Assistant Obstetric Surgeon, St. Mary's Hospital, Manchester; Assistant Lecturer in Obstetrics and Gynaecology, University of Manchester.
"Intractable Sciatica Due to Prolapsed Intervertebral Disc.," by Norman Capener, F.R.C.S., Orthopaedic Surgeon, Princess Elizabeth Hospital, Exeter, and Mount Gold Orthopaedic Hospital, Plymouth.

**"Post-Graduate Medical Journal"—March, 1938.**

"Debate on Abortion," Wednesday, February 9th, 1938. The Hon. Mr. Justice Humphreys in the Chair.

**"The Journal of Obstetrics and Gynaecology of the British Empire"—December, 1937.**

"Maternal Mortality in Hospital Practice," by H. I. McClure, M.B., B.Sc. (Belfast), F.R.C.S. (Edin.), M.C.O.G., Assistant Surgeon and Registrar, Royal Maternity Hospital, Belfast; Gynaecological Surgeon, Ulster Hospital for Children and Women; Lecturer in Obstetrics and Gynaecology, Queen's University, Belfast.
"Analysis of 496 Private Obstetric Cases," by C. H. G. Macafee, M.B., B.Ch. (Belfast), F.R.C.S. (Eng.), F.R.C.S.I., F.C.O.G., Surgeon-in-charge of Out-Patients, Royal Maternity Hospital, Belfast; Assistant Gynaecologist, Royal Victoria Hospital, Belfast; Lecturer in Obstetrics and Gynaecology, Queen's University, Belfast.
"An Exact Method of Determining Ovulation and Pregnancy," by J. Samuels, M.D., Chief of the Institute for Short-wave Therapy, Amsterdam.
"The Intra-Abdominal Pressure in Pregnancy Newly Considered," by R. H. Paramore, F.R.C.S. (Eng.). The Manometer and the Method.
"The Immediate Cause of Menstruation," by J. Beatty, M.D. (Dub.), M.R.C.P. (Lond.), D.P.H., R.C.P., S.I., Consulting Dermatologist to the Royal Infirmary, Cardiff.
"A Large Ovarian Cyst," by H. A. Kidd, F.R.C.S. (Edin.), Medical Superintendent, Surrey County Hospital.
"A Method of Performing Lower Segment Caesarean Section, with Special Reference to a New Compressor Instrument," by H. B. Butler, M.B.E., F.R.C.S. (Edin.), Surgeon in Charge of the Gynaecological Department, Royal Surrey County Hospital, Guildford.
"On Cross Section of the Perineum: A Simple Method of Limiting Rupture in Labour," by R. K. Howat, M.B., C.M. (Glas.), F.R.C.S. (Eng.), F.R.F.P.S.G.
"The Surgical Treatment of Cysts of the Vulva and Vagina," by J. R. Goodall, O.B.E., B.A., M.D., C.M. (McGill), D.Sc. (McGill), F.C.O.G., F.A.C.S., and F. L. MacPhail. From the Wards and Research Laboratory of St. Mary's Hospital, Montreal.
"Fibroma of the Ovary: A Clinical Study," by Muriel B. McIlrath, M.B., B.S. (Sydney), F.R.C.S. (Eng.), M.C.O.G., Resident Obstetrical Officer, Withington Hospital, Manchester; Late House Surgeon, St. Mary's Hospital, Manchester.
"Radiograms taken during Labour from its onset until the Head is Born, indicating the Position of the Anterior and Posterior Shoulders," by N. A. Purandare, M.D., F.C.P.S., Hon. Visiting Obstetrician, Sir N. M. Wadia Maternity Hospital; Hon. Gynaecologist, King Edward Memorial Hospital, Bombay; Hon. Lecturer in Midwifery and Gynaecology, Seth G. S. Medical College, Bombay.

**"The Practitioner"—January, 1938.**

"The Use of Thyroid Preparations," by George R. Murray, M.A., M.D., F.R.C.P., Emeritus Professor of Medicine, Victoria University of Manchester.
"The Use of Parathyroid Preparations and Calcium Salts," by Donald Hunter, M.D., F.R.C.P., Physician with Charge of Out-Patients, the London Hospital.
"The Use of Adrenal Gland Hormones in Treatment," by S. Levy Simpson, M.A., M.D., M.R.C.P., Physician Willesden General Hospital; Assistant Physician, Princess Louise Kensington Hospital for Children; Consulting Physician, the Soho Hospital for Women.
"The Use of Pituitary Preparations," by P. M. F. Bishop, B.M., B.Ch., Clinical Endocrinologist, Guy's Hospital.
"The Use of Female Sex Hormones in Treatment," by Douglas MacLeod, M.S., M.R.C.P., F.R.C.S., M.C.O.G., Assistant Obstetric Surgeon, St. Mary's Hospital; Surgeon to Out-Patients, Queen Charlotte's Maternity Hospital, and the Hospital for Women, Soho Square.
"The Use of Male Sex Hormones," by E. W. Riches, M.C., M.S., F.R.C.S., Surgeon to Out-Patients and Assistant Urologist, Middlesex Hospital; Surgeon, the Hospital of St. John and St. Elizabeth; Consulting Urologist to the London County Council.
"Diet in Health and Disease. VII.—Diet in Endocrine Disorders and Obesity," by D. M. Lyon, M.D., D.Sc., F.R.C.P.E., Professor of Clinical Medicine, University of Edinburgh; Physician Consultant, Royal Infirmary, Edinburgh.
"The Clinical Picture of Acute Appendicitis," by Harold Dodd, Ch.M., F.R.C.S., Surgeon, King George Hospital, Ilford, and Royal Hospital, Richmond.

"Injection Treatment of Hernia," by Maurice Lee, Royal Waterloo Hospital.
M.B., B.S., F.R.C.S. Late Surgical Registrar,

**"The Practitioner"—February, 1938.**

"Abdominal Pain as a Guide to Diagnosis and Treatment," by John Morley, Ch.M., F.R.C.S., Professor of Surgery, Manchester University; Honorary Surgeon, Manchester Royal Infirmary.
"The Diagnosis and Treatment of Pain Referred to the Abdomen from the Thoracic Organs," by Maurice Davidson, M.A., D.M., F.R.C.P., Physician, Brompton Hospital for Diseases of the Chest.
"The Significance and Treatment of Indigestion," by Ernest Bulmer, M.D., F.R.C.P., Physician, General Hospital, Birmingham.
"The Significance and Treatment of Vomiting," by Geoffrey Evans, M.D., F.R.C.P., Physician, St. Bartholomew's Hospital, London.
"The Significance and Treatment of Diarrhoea in Adults," by S. W. Patterson, M.D., D.Sc., F.R.C.P., Physician, Ruthin Castle.
"The Significance and Treatment of Obstinate Hiccough," by E. Bellingham-Smith, M.D., F.R.C.P., Physician, St. George's Hospital, London.
"Laboratory Methods in the Diagnosis of Gastro-Intestinal Disorders," by R. G. Waller, M.R.C.S., L.R.C.P., Director of the Pathological Department, West London Hospital.
"The Management of Insomnia," by Henry Cohen, M.D., F.R.C.P., Professor of Medicine, University of Liverpool; Honorary Physician, Royal Infirmary, Liverpool.
"The Testamentary Competency of a Patient with Aphasia," by MacDonald Critchley, M.D., F.R.C.P., Neurologist, King's College Hospital; Physician to Out-Patients, the National Hospital, Queen Square, London.
"Varieties of Cardiac Dyspnoea," by R. O. Moon, D.M., F.R.C.P., Consulting Physician, Royal Waterloo Hospital, and the Hospital for Diseases of the Heart.
"Diet in Health and Disease. VIII.—Diet in Kidney Disease," by Robert Platt, M.D., F.R.C.P., Physician, the Royal Infirmary, Sheffield.

**"The Practitioner"—December, 1937.**

"The Development of Chemotherapy for Bacterial Diseases," by Prof. H. Hoerlein, W.-Elberfeld.
"The Assessment of the Efficiency of Chemotherapeutic Substances," by Lionel E. H. Whitby, C.V.O., M.C., M.D., F.R.C.P., Assistant Pathologist, The Bland-Sutton Institute of Pathology, The Middlesex Hospital.
"The Use of Antistreptococcal Preparations in General Practice," by A. H. Douthwaite, M.D., F.R.C.P., Physician, Guy's Hospital.
"The Use of Antistreptococcal Preparations in Obstetrics," by Arthur C. Bell, M.B., B.S., F.R.C.S., M.C.O.G., Assistant Obstetric Surgeon, Westminister Hospital; Surgeon, Queen Charlotte's Maternity Hospital; Out-Patient Surgeon, Chelsea Hospital for Women.
"The Nomenclature and Dosage of New Antistreptococcal Preparations," by W. K. Fitch, Editor, The Pharmaceutical Journal.
"Acute Pulmonary Oedema: Its Pathogenesis and Treatment," by Maurice Campbell, D.M., F.R.C.P., Physician, Guy's Hospital, and the National Hospital for Diseases of the Heart.
"Environment in the Treatment of Psychoneuroses," by Grace Nicolle, M.A., M.B., Physician, the Tavistock Clinic.
"The Stammering Habit: Correction Through Speech Re-Education," by H. St. John Rumsey, M.A., Speech Therapist and Lecturer, Guy's Hospital.
"Diet in Health and Disease. VI.—Diet in Gastric Diseases," by Maurice E. Shaw, D.M., F.R.C.P., Physician, West London Hospital.

## NOTICE

THE RURAL MUNICIPALITY OF ERIKSDALE advises that there is an opportunity for a resident medical practitioner at Eriksdale, Manitoba. Anyone interested may obtain full information by writing H. S. Rutherford, Secretary of the Municipality.

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